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Center *for* Rural Health
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Fact Sheet

Critical Access Hospital Organizational Conditions

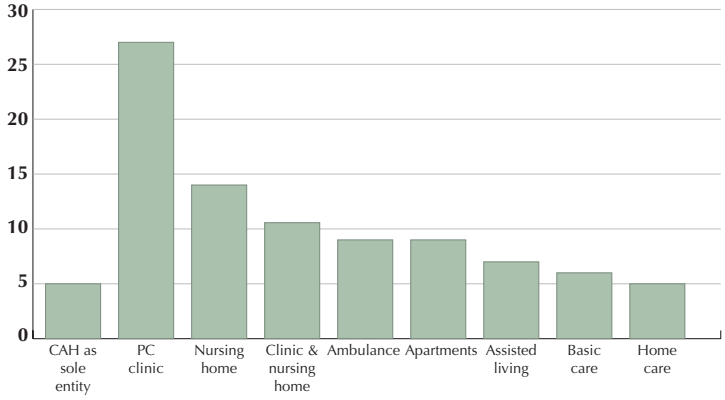
Part of a series of fact sheets on Critical Access Hospitals and the North Dakota Medicare Rural Hospital Flexibility (Flex) program.

Certain environmental conditions shape the organizational structure of Critical Access Hospitals (CAHs), how they operate, and the services they offer. The Center for Rural Health examined these conditions by surveying North Dakota CAH administrators three times (in 2011, 2008, and 2005) about a wide range of subjects and also collecting additional material provided by the North Dakota Rural Health Association (NDRHA).

Snapshot of North Dakota CAH Organizational Structure and Services

- CAHs are small rural hospitals with a maximum bed count of up to 25 beds. There are 36 CAHs in North Dakota. All North Dakota rural hospitals, with the exception of the two Indian Health Service hospitals have converted (See Figure 1).

Figure 1. CAH Organizational Structure



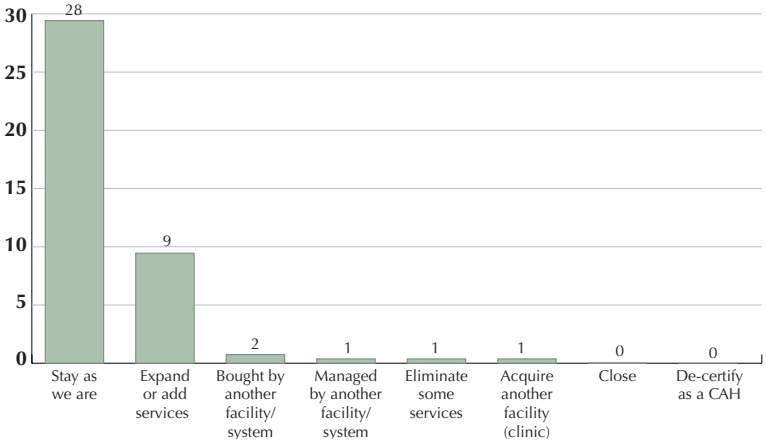
- In North Dakota, 94% of CAHs had an average daily census of five patients or less compared to just under 60% nationally.[1]
- The median acute care average daily census of North Dakota CAHs was 1.66, based on 2009 statistics.[2]
- Nationally, CAHs had an average daily census of 4.20. Neighboring states had the following: Minnesota, 3.86; Montana, 1.75; and South Dakota, 1.73. North Dakota ranks third behind Alaska (1.42) and Hawaii (0.10).
- While North Dakota CAHs typically provide a lower volume of acute care services, they are highly diversified and provide vital access to a range of health services in rural North Dakota. For example, North Dakota CAHs commonly serve as the primary organizational arrangement of other essential health services. They serve as the "hub" for services acting more like a health or medical center than a traditional hospital.
- Only five of the 36 CAHs in North Dakota (14%) are "stand alone" sole-entity hospitals offering exclusively traditional hospital services.[3] Most CAHs own and operate a primary care clinic and/or a nursing home, and many offer additional services (See Figure 1).
- North Dakota CAHs also increase access to primary care services as they operate 60 clinics with 47 of these clinics being organized as Federally-certified rural health clinics (RHCs). CAHs operate 78% of all RHCs in the state.

Looking to the Future

- When asked to contemplate future change for their operations over the next 12 months, a significant majority of North Dakota CAH administrators (82%) expected to stay the same. Nine CAH administrators (26%) anticipated adding services and one expected to discontinue home care. Only two administrators thought their facility would be acquired by another hospital system, and one anticipated a new management structure (See Figure 2).
- Strong majorities of administrators surveyed in 2005 (85%) and 2011 (82%) believed that their CAH would stay the same over the next 12 months. This contrasts somewhat with 2008, when 58% believed this.
- The 2011 respondents were significantly more confident that they would add or expand services, with nine in 2011 indicating that this was likely compared to only four in 2008 and one in 2005.
- In 2011 and 2005, no CAH administrator contemplated closing their facility; however, in 2008, two CAH administrators did. Also in 2008, two administrators

expected to decertify their facility as CAHs; no one expressed that view in response to either the 2005 or the 2011 survey.

Figure 2. Expected Change in CAH Structure Over 12 Months



Conclusions

- In general, CAHs provide a lower volume of acute care services. Demographics, medical practice, reimbursement policy, and other factors have lessened the demand for acute services and changed how and even when health/ medical care is provided in rural areas.
- Most CAHs in North Dakota are diversified, providing access in a hub-like arrangement to an increasingly-wide array of non-acute care services meeting local needs for other essential services such as primary care, EMS, long term care, aging services, and other services. In many cases the CAH owns and/or operates these services as one entity.
- In many rural North Dakota communities, CAHs are not just a pivotal point of access to essential care, they are also the official gateway to local health services and/ or referrals. If it were not for the CAH, access would not exist. CAHs are, therefore, a fundamental part of the health safety net in the state.
- The data compiled by the NDRHA establishes the clear organizational connection between rural hospitals and rural clinics. Three quarters of the state's CAHs own and operate clinics, with most of them being federally certified RHCs. This is important to securing a level of primary care in rural North Dakota as over the last 10 years the number of RHCs had declined from 85 to 59. With 80% of the RHCs in the state being owned by CAHs, the decline in the number of RHCs has been in the independent RHC that is not affiliated with a hospital or health system.
- In many respects, the rural primary care clinic structure in North Dakota survives today due to the organizational, financial, and staffing support of the CAH system. As CAHs are threatened by financial constraints, workforce shortages, regulatory demands, and other factors, so too is the overall rural health system that supports clinics, ambulances, long term care, and other important health services in North Dakota.
- North Dakota CAH administrators surveyed in 2011 did not expect much structural change during the next 12 months, which may indicate some degree of stability. This is encouraging, considering the relatively fragile nature of North Dakota CAHs, which exist in an environment influenced by financial conditions, workforce demands, population change, and new organizational arrangements with larger tertiary systems.
- The fact that over one-quarter of surveyed North Dakota CAH administrators are contemplating expanding or adding new services indicates both confidence in their facility's future and a recognition that increasing the availability of local services can contribute to improving local health status. The diversity of services controlled by most CAHs in North Dakota indicates that these facilities not only provide access to rural safety net services that may not be available under other arrangements, but also serve as a "hub" for local services offering economies of scale. This may prove beneficial to the broader community through increasing employment and school enrollment, as well as expanding the tax base.

References

[1] http://www.flexmonitoring.org/documents/Finance/2011/StGraph_ND2011.pdf. Retrieved December 14, 2011.

[2] CAH Financial Indicators Report: Summary of Indicator Medians by State. Flex Monitoring Team Data Summary Report No. 9. University of Minnesota, University of North Carolina at Chapel Hill, and University of Southern Maine. August 2011.

[3] North Dakota Rural Health Association, non-published data, Darrold Bertsch, President, NDRHA and CEO Sakakawea Medical Center, October 2011.

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